U.S. Department of Labor

Office of Administrative Law Judges 36 E. 7th St., Suite 2525 Cincinnati, Ohio 45202



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Issue Date: 02 July 2007

In the Matter of:		
B.D., Claimant	Case No.:	2005-BLA-05204
v.		
J.J. COAL COMPANY, INC., Employer		

ZURICH AMERICAN INSURANCE GROUP, Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS, Party-in-Interest

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Appearances:

Thomas W. Moak, Esq. Moak & Nunnery Prestonsburg, Kentucky For the Claimant

Lois A. Kitts, Esq. Baird & Baird, PSC Pikeville, Kentucky For the Employer

Phillip Giannikas, Esq.
Office of the Solicitor
Nashville, Tennessee
For the Director, OWCP

Before: Alice M. Craft

Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901, et seq. The Act and implementing regulations, 20 CFR Parts 410, 718, 725, and 727, provide compensation and other benefits to living coal miners who are totally disabled due to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b); 20 CFR § 718.201 (2006). In this case, the Claimant alleges that he is totally disabled by pneumoconiosis.

I conducted a hearing on this claim on Pikeville, Kentucky, on December 6, 2005. All parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure before the Office of Administrative Law Judges, 29 CFR Part 18 (2006). At the hearing, there were three witnesses, the Claimant, Transcript ("Tr.") 18-32, and two representatives of Wright Coal Company (the alleged successor to the Employer), an accountant, Tr. 33-54, and the owner, Tr. 55-71. Director's Exhibits ("DX") 1-58, Claimant's Exhibits ("CX") 1-7, and Employer's Exhibits ("EX") 1-2 were admitted into evidence without objection. Tr. 6-8, 13-14, and 15-16. The Employer reserved any objections to the Claimant's exhibits pending post-hearing confirmation that it had received copies, and that the Claimant had not exceeded the evidentiary limits found in 20 CFR § 725.414. Tr. 10-14. The Employer objected to DX 59, and proposed DX 60 and 61, because they were submitted less than 20 days before the hearing. I overruled the objection, with the proviso that the record would be held open to allow the Employer to submit responsive evidence. Tr. 7, 49-52. The Employer's motion for remand to the District Director, OWCP, was denied, absent agreement from the Director. Tr. 52-54. The record was held open after the hearing to allow the parties to submit additional evidence and argument. Tr. 71-74. I hereby admit the following additional exhibits which were submitted by the parties after the hearing: DX 60 and 61, and EX 4-6 and 8-9. I have excluded EX 7, two re-readings of x-rays taken during medical treatment of the Claimant, for the reason stated in note 4 below. The Claimant, Employer, and Director submitted closing arguments, and the record is now closed.

In reaching my decision, I have reviewed and considered the entire record, including all exhibits admitted into evidence, the testimony at hearing, and the arguments of the parties.

PROCEDURAL HISTORY

The Claimant filed his initial claim on November 15, 1999. DX 1. The claim was denied by the District Director of the Office of Workers' Compensation Programs ("OWCP") on March 22, 2000, on the ground that the evidence did not show that the Claimant was totally disabled due to pneumoconiosis. The Claimant did not appeal that determination.

The Claimant filed his current claim on August 25, 2003. DX 3. The Director issued a proposed Decision and Order awarding benefits on May 24, 2004. DX 36. The Employer

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¹ The Employer submitted, but failed to offer into evidence, EX 3, the qualifications of Dr. Wheeler. However, the Employer later offered his curriculum vitae as EX 9.

moved for reconsideration on whether it was correctly named as the responsible operator, and filed a protective appeal, on June 3, 2004. DX 38, 39. On July 26, 2004, the Director issued a revised Proposed Decision and Order awarding benefits, naming J.J. Coal Company as the responsible operator. DX 49. The Employer appealed this decision on August 13, 2004. DX 51. The claim was referred to the Office of Administrative Law Judges for hearing on October 27, 2004. DX 56.

APPLICABLE STANDARDS

This claim relates to a "subsequent" claim filed on August 25, 2003. Because the claim at issue was filed after March 31, 1980, and after January 19, 2001, the effective date of the current regulations, the current regulations at 20 CFR Parts 718 and 725 apply. 20 CFR §§ 718.2 and 725.2 (2006). Pursuant to 20 CFR § 725.309(d) (2006), in order to establish that he is entitled to benefits, the Claimant must demonstrate that "one of the applicable conditions of entitlement ... has changed since the date upon which the order denying the prior claim became final" such that he now meets the requirements for entitlement to benefits under 20 CFR Part 718. In order to establish entitlement to benefits under Part 718, the Claimant must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis is totally disabling. 20 CFR §§ 718.1, 718.202, 718.203, 718.204, and 725.103 (2006). I must consider the new evidence and determine whether the Claimant has proved at least one of the elements of entitlement previously decided against him. If so, then I must consider whether all of the evidence establishes that he is entitled to benefits. *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994).

ISSUES

The issues contested by the Employer are:

- 1. Whether the claim was timely filed.
- 3. Whether the Claimant has pneumoconiosis as defined by the Act and the regulations.
- 4. Whether his pneumoconiosis arose out of coal mine employment.
- 5. Whether he is totally disabled.
- 6. Whether his disability is due to pneumoconiosis.
- 9. Whether the named Employer is the Responsible Operator.
- 10. Whether the evidence establishes that one of the applicable conditions of entitlement has changed pursuant to 20 CFR § 725.309 (2006).

DX 56; Tr. 17. The Employer withdrew the issue of whether the Claimant was a miner. Tr. 17. The Employer also reserved its right to challenge the statute and regulations. Tr. 17.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and the Claimant's Testimony

The Claimant testified at the hearing in December 2005 and at a deposition held in April 2004. DX 18. He was 50 years old at the time of the hearing. He has a twelfth-grade education. Tr. 19. He was divorced in 1991 and remarried in 2001. DX 18-6, 12, 13. He has no dependent children. DX 18-6-7.

The Claimant said that he worked in the coal mines for 24½ years, all underground. The parties agreed that the Claimant had at least 24 years of coal mine employment. Tr. 16. During his coal mine employment, he worked as a roof bolter, shuttle car operator, and continuous miner operator. According to the Claimant, he was exposed to coal dust in each of these jobs. Tr. 19-22. He testified that he last worked on April 30, 1999. Tr. 19; DX 18-7-8. He left because he was having trouble with his breathing and his back. His breathing was causing him the most trouble. Tr. 22; DX 18-8-9. His last coal mine employment was in Kentucky. Tr. 31; DX 4. Therefore, this claim is governed by the law of the Sixth Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (*en banc*).

The Claimant testified that he began to have breathing problems prior to leaving the mines. He suffered with wheezing, coughing, and shortness of breath. His breathing has gotten worse since he left the mines. Because of these breathing problems, he is only able to walk about 50 feet before having to rest. He avoids climbing the stairs because of his breathing issues and can only mow the grass on a riding lawn mower. The Claimant stated that his breathing problems alone would prevent his return to coal mine work. Tr. 23-24.

Dr. Sikder has been treating the Claimant for his breathing condition since 2003. Tr. 24-25; DX 18-22, 28. His treatment includes a nebulizer, pills, and inhalers. DX 18-23-24. The Claimant testified that Dr. Sikder told him he was totally disabled due to pneumoconiosis. The Claimant also goes to the Mud Creek Clinic. DX 18-26. He stated that he had a biopsy of his right lung in June or July of 1999, which the doctors told him was positive for black lung. DX 18-28.

The Claimant began smoking in 1976 at the age of 21, at a rate of one-half of a pack per day. He said he quit approximately two years before the date of the hearing. Tr. 26. At his deposition in April 2004, he said he quit two months before. DX 18-25-26.

Timeliness

Under § 932(f) of the Act, 30 U.S.C. § 932(f), implemented at 20 CFR § 725.308(a), a claim of a living miner is timely filed if it is filed "within three years after a medical determination of total disability due to pneumoconiosis" has been communicated to the miner. The Sixth Circuit has interpreted this to mean:

The three-year limitations clock begins to tick *the first time* that a miner is told by a physician that he is totally disabled by pneumoconiosis. This clock is not stopped by the resolution of the miner's claim or claims, and ... may only be turned back if the miner returns to the mines after a denial of benefits.

Tennessee Consolidated Coal Co. v. Kirk, 264 F.3d 602, 608 (6th Cir. 2001) (emphasis in original). Twenty CFR § 725.308(c) creates a rebuttable presumption that every claim for benefits is timely filed. The Claimant filed his claim on August 25, 2003. At the hearing, the Claimant said that Dr. Sikder told him he is totally disabled due to pneumoconiosis. The record indicates that she first saw the Claimant in 2003. There is no evidence in the file that the Claimant was ever told that he was totally disabled by pneumoconiosis before he began seeing Dr. Sikder. According to the initial black lung claim, after his pneumoconiosis was diagnosed by x-ray and lung biopsy, his family doctor advised him to stay away from dust and fumes. DX 1-83. This recommendation, in and of itself, however, does not constitute an articulation of disability pursuant to the regulations or case law, as it does not foreclose comparable work in a dust-free environment. See Zimmerman v. Director, OWCP, 871 F.2d 564, 567 (6th Cir. 1989). At most, it appears that he was told that he had "real bad black lung," DX 18-28, or that his "lungs were in terrible bad shape" because of black lung, DX 18-29, around the time of his biopsy in 1999. I do not find this sufficient to invoke the statute of limitations. The Employer has offered no evidence or argument on this issue. I find that the presumption has not been rebutted, and the claim is timely.

Responsible Operator

The Employer argues that J.J. Coal Company ("J.J.") is not the responsible operator because the Claimant worked for Wright Coal Company ("Wright") after he worked for J.J. The parties agree that Wright took over the mine from J.J. J.J. maintains that Wright is a successor in interest and should assume any liability. The Director, OWCP, on the other hand, argues that J.J. is correctly named as the responsible operator because Wright did not employ the Claimant.

The Claimant testified that he worked at the same mine from 1989, when its name was Good Times Mining, until April 1999. At the very end of his employment, J.J. leased the mine to Wright Coal Company. The Claimant said that he thought he worked one or two days for Wright but never received payment for that work. He was not sure whether Wright had acquired the mine when he worked that day, but he had been off, and when he returned, he assumed Mr. Wright was in charge. Tr. 28-30; DX 18-9-12, 14-15, 18-20. He agreed that his recollection was pretty hazy. Tr. 32.

Gladys Funk also testified at the hearing. She testified that she is a self-employed accountant with her own tax office. She prepares state and federal taxes, and does a little payroll and bookkeeping. She prepared Mr. Wright's tax returns, and when he started Wright Coal Company, she did the payroll. Tr. 34. Her payroll records for Wright were introduced into evidence as DX 59. Tr. 35. She agreed that Wright took over J.J.'s coal operation on a lease basis. Tr. 36. She stated that the Claimant and other individuals listed on page 1 of DX 59 never worked for Mr. Wright. Tr. 37-38, 41. She said that Mr. Wright had to "absorb J.J.'s final payroll obligations" as a condition of the lease. Tr. 38, 42. She further testified that she did not prepare a "new hire" form for the Claimant (required by Kentucky for all employees of Wright Coal Company), because the Claimant was not an employee of Mr. Wright. Tr. 43-44. Review of the list she submitted to the Kentucky New Hire Reporting Center confirms that the Claimant was not on the list of new employees. DX 60. See also, DX 53. Ms. Funk testified that she prepared a payroll sheet for the Claimant, DX 59-6, because she had to prepare a W-2 form for the pay he received from Wright for work done for J.J. Tr. 46-48; DX 61.

Troy Wright was the owner of Wright Coal Company. He testified that he worked as a coal miner until 2002. Tr. 56. Prior to starting Wright Coal Company, Mr. Wright was employed by J.J. for a few months, as superintendent electrician. The owner of J.J., Mack Stiltner, had a heart attack, and asked Mr. Wright to take over the mines. Tr. 58. At that point, Mr. Wright leased the mines from Mr. Stiltner. In order to continue operation of the mine, Mr. Wright used J.J.'s equipment, and those employees from J.J. that wanted to stay and work; this did not include all the employees. Tr. 58-59, 63. Mr. Wright was unable to remember if the Claimant was one of the employees that previously worked for J.J. who stayed on. He was able to recall that the Claimant worked for J.J. as a continuous miner operator. Tr. 59-60, 68. He paid people from J.J. with money that Mr. Stiltner gave him to help him get started working the mine. Tr. 64, 66. He did not disagree with Ms. Funk's testimony in any respect. He said he went to her to make sure that everything was done right. Tr. 70.

Twenty CFR § 725.492 defines a successor operator as follows:

Any person who, on or after January 1, 1970, acquired a mine or mines, or substantially all of the assets thereof, from a prior operator, or acquired the coal mining business of such prior operator, or substantially all of the assets thereof, shall be considered a 'successor operator' with respect to any miners previously employed by such prior operator.

20 C.F.R. §725.492(a). Section 725.492(b) lists additional transactions which will be deemed to create successor operator liability. Additionally, § 725.492(e) provides that "[a]n 'acquisition,' for purposes of this section, shall include any transaction by which title to the mine or mines, or substantially all of the assets thereof, or the right to extract or prepare coal at such mine or mines, becomes vested in a person other than the prior operator." 20 C.F.R. §725.492(e). In this case, Mr. Wright leased the mines from Mr. Stiltner, and Mr. Wright used J.J.'s equipment and hired some of its employees. As a result of this lease, it appears that Wright acquired substantially of all of J.J.'s assets, and the right to extract coal, at the mine in question. Thus, I find that Wright Coal Company is a successor operator within the meaning of the regulation. Section 725.492(d) also provides, however, "[t]his section shall not be construed to relieve a prior operator of any liability if such prior operator meets the conditions set forth in Sec. 725.494." Section 725.494 sets forth the conditions for identifying potentially liable operators, including successor operators.

The next issue is whether J.J. should be relieved of liability because of Wright's status as a successor operator. Twenty CFR § 725.494 provides as one of the requirements for liability that "[t]he miner was employed by the operator, or any person with respect to which the operator may be considered a successor operator, for a cumulative period of not less than one year (Sec. 725.101(a)(32))." The term "employed" and "employment" are specifically defined in the regulations and provide specific examples of what relationship will be considered employment under the regulations. Section 725.493(a)(2) states that the payment of wages is *prima facie* evidence of an employment relationship, but the absence of such payment does not negate such a relationship. In a list of examples of what may constitute an employment relationship, the rule goes on to state,

(1) In any case in which an operator may be considered a successor operator, as determined in accordance with Sec. 725.492, any employment with a prior operator shall also be deemed to be employment with the successor operator. In a case in which the miner was not independently employed by the successor operator, the prior operator shall remain primarily liable for the payment of any benefits based on the miner's employment with the prior operator. In a case in which the miner was independently employed by the successor operator after the transaction giving rise to successor operator liability, the successor operator shall be primarily liable for the payment of any benefits.

20 CFR § 725.493(b)(1).

Considering the testimony of all three witnesses, I find that the testimony of Ms. Funk is the most reliable concerning the question of whether the Claimant was ever employed by Wright. Both the Claimant and Mr. Wright expressed uncertainty. Ms. Funk's testimony that the Claimant was never employed by Wright, on the other hand, was supported by her records of the work she performed for Wright. I find that the Claimant was never employed by Wright, and the payment he received from Wright for 26.5 hours of work was for work performed as an employee of J.J. As I have concluded that the Claimant was employed by J.J. but not by Wright, applying § 725.493(b)(1), I conclude that J.J., the prior operator, is liable for the payment of any benefits due to the Claimant.

Change in Conditions

In a subsequent claim, the threshold issue is whether one of the applicable conditions of entitlement has changed since the previous claim was denied. The Claimant's previous claim was denied by the District Director on March 22, 2000, and the denial became final one year later. The District Director found that the Claimant had pneumoconiosis, but that he was not disabled due to pneumoconiosis. As will be discussed in more detail below, I have found that the evidence in the current claim demonstrates that the Claimant has complicated pneumoconiosis. Moreover, pulmonary function tests, arterial blood gas studies, and medical reports also indicate that the Claimant now has a pulmonary impairment which is totally disabling. This constitutes a material change in conditions.² Because the new evidence establishes that a material change in conditions has occurred, I must consider all of the evidence in the record in reaching my decision

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In *Grundy Mining Co. v. Director, OWCP [Flynn]*, 353 F.3d 467 (6th Cir. 2003), a multiple claim arising under the pre-amendment regulations at 20 C.F.R. § 725.309 (2000), the Court reiterated that its previous decision in *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994), requires that the ALJ resolve two specific issues prior to finding a "material change" in a miner's condition: (1) whether the miner has presented evidence generated since the prior denial establishing an element of entitlement previously adjudicated against him; and, (2) whether the newly submitted evidence differs "qualitatively" from evidence previously submitted. Specifically, the *Flynn* Court held that "miners whose claims are governed by this Circuit's precedents must do more than satisfy the strict terms of the one-element test, but must also demonstrate that this change rests upon a qualitatively different evidentiary record." *See also, Tennessee Consolidated Coal Co. v. Kirk*, 264 F.3d 602, 608-610 (6th Cir. 2001). Once a "material change" is found, then the ALJ must review the entire record *de novo* to determine ultimate entitlement to benefits. As the discussion below demonstrates, the record in the current claim is qualitatively different from the prior claim on the issue of whether the Claimant is totally disabled by a pulmonary or respiratory impairment: first, because x-rays and medical opinions establish that the Claimant has complicated pneumoconiosis; and, second, because other objective test results show substantial decline in the Claimant's lung function since Dr. Forehand said that he had no impairment.

whether he is now entitled to benefits. Evidence admitted in the prior claim may be considered notwithstanding the limitations on the introduction of evidence contained in 20 CFR § 725.414 (2006). 20 CFR § 725.309(d)(1) (2006). Moreover, no findings in the prior claim are binding, unless a party fails to contest an issue, or made a stipulation in a prior claim. 20 CFR § 725.309 (d)(4) (2006).

Medical Evidence

Biopsy

Biopsies may be the basis for a finding of the existence of pneumoconiosis. A finding of anthracotic pigmentation is not sufficient, by itself, to establish pneumoconiosis. 20 CFR § 718.202(a)(2) (2006). Section 718.106(a) provides that a biopsy report shall include a detailed gross macroscopic and microscopic description of the lungs or visualized portion of a lung. If a surgical procedure was performed to obtain a portion of a lung, the evidence should include a copy of the surgical note and the pathology report. The Benefits Review Board has held, however, that the quality standards are not mandatory and failure to comply with the standards goes only to the reliability and weight of the evidence. *Dillon v. Peabody Coal Co.*, 11 B.L.R. 1-113, 1-114 (1988); *see Dagnan v. Black Diamond Coal Mining Co.*, 994 F.2d 1536, 1540-1541 (11th Cir. 1992). Section 718.106(c) provides that "[a] negative biopsy is not conclusive evidence that the miner does not have pneumoconiosis. However, where positive findings are obtained on biopsy, the results will constitute evidence of the presence of pneumoconiosis." The Claimant underwent biopsies in 1999, 2003, and 2004.

The first biopsy was performed in July 1999 at the University of Virginia. The Pathologist's report is not in evidence. However, Dr. P. Raphael Caffrey reviewed the pathology report by Dr. Cerrilli, and 10 surgical pathology slides from the Claimant's lungs, and prepared a report dated January 30, 2006. EX 5. Dr. Caffrey said that the slides originated from a wedge resection of the Claimant's right upper lobe measuring 6.0 x 1.5 x 1.5 cm. The sectioned specimen revealed a few nodules, the largest measuring 0.9 cm. He observed anthracotic pigment, lesions of simple coal workers' pneumoconiosis, and interstitial fibrosis with associated anthracotic pigment. In some areas he saw birefringent particles of silica and silicates. Dr. Caffrey noted no lesions of complicated pneumoconiosis. Based upon this examination of the pathology slides, Dr. Caffrey diagnosed simple nodular silicosis, and simple macular and micronodular coal workers' pneumoconiosis.

The Claimant underwent a CT guided needle biopsy of the right lung on May 23, 2003. According to the gross description, the specimen consisted of a 0.7 x 0.5 x 0.2 cm aggregate of hemorrhagic material. Microscopic examination showed some small fibrous plaques with intermixed black pigment. The final diagnosis was anthracosis and fibrosis suggestive of coal workers' pneumoconiosis, with no evidence of granulomatous inflammation or neoplasm. CX 2.

Dr. Sikder performed a bronchoscopy with biopsies, brushings, and lavage on February 23, 2004. CX 3. The biopsy report is not in the record.

In accordance with 20 CFR § 718.106(c), the biopsy evidence establishes that the Claimant has pneumoconiosis.

Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The following table summarizes the x-ray findings available in this case. X-ray interpretations submitted by the parties in connection with the current claim in accordance with the limitations contained in 20 CFR § 725.414 (2006) appear in bold print.

The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B, or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 CFR § 718.102(b) (2006). Any such readings are, therefore, included in the "negative" column. X-ray interpretations which make no reference to pneumoconiosis, positive or negative, given in connection with medical treatment or review of an x-ray film solely to determine its quality, are listed in the "silent" column. In addition, some x-rays were found by some readers to be unreadable due to poor quality. Those have also been listed in the "silent" column. X-ray readings exceeding the limitations do not appear on the table. *See* note 4 below.

Physicians' qualifications appear after their names. Qualifications of physicians who read x-rays in connection with the black lung claims have been obtained where shown in the record by curriculum vitae or other representations or, if not in the record, by judicial notice of the lists of readers issued by the National Institute of Occupational Safety and Health (NIOSH), and/or the registry of physicians' specialties maintained by the American Board of Medical Specialties. Qualifications of physicians are abbreviated as follows: A=NIOSH-certified A reader; B=NIOSH-certified B reader; BCR=Board-certified in Radiology. Readers who are Board-certified Radiologists and/or B readers are classified as the most qualified. *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B readers need not be Radiologists.

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NIOSH is the Federal Government agency that certifies physicians for their knowledge of diagnosing pneumoconiosis by means of chest x-rays. Physicians are designated as "A" readers after completing a course in the interpretation of x-rays for pneumoconiosis. Physicians are designated as "B" readers after they have demonstrated expertise in interpreting x-rays for the existence of pneumoconiosis by passing an examination. Historical information about physician qualifications appears on the U.S. Department of Health and Human Services, Comprehensive List of NIOSH Approved A and B Readers, February 2, 2007, found at http://www.oalj.dol.gov/PUBLIC/BLACK_LUNG/REFERENCES/REFERENCE_WORKS/BREAD3_02_07.HTM. Current information about physician qualifications appears on the CDC/NIOSH, NIOSH Certified B Readers List found at http://www.cdc.gov/niosh/topics/chestradiography/breader-list.html. Information about physician board certifications appears on the website of the American Board of Medical Specialties, found at http://www.abms.org. The parties were notified at the hearing that I proposed to take judicial notice of physician qualifications listed on the Internet by these organizations, and had no objection to my doing so. Tr. 16.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
06/01/99			CX 4 Filsinger Multiple well-circum- scribed round nodules both lungs, largest nodule measures approximately 1.5 cm diameter. Multiple pulmonary nodules most likely represent metastases. Fibrosis in a reticular nodular pattern.
07/16/99			CX 4 Zban No evidence of pneumo- thorax s/p chest tube placement.
07/17/99			CX 4 De Lange Chest tube on the right, marked opacification right lower lobe, infiltrate or edema; left lung clear.
07/18/99			CX 4 Shaffer S/p chest tube removal, persistent pleural disease bilaterally.
05/20/03			CX 1 Grimes Diffuse alveolar infiltration in the upper lobes bilaterally consistent with bilateral pneumonia

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
05/21/03			CX 1 Davis Widespread innumerable varying sized non- calcified pulmonary nodules. Active TB/fungal disease or widespread thoracic malignancy are the major considerations.
05/22/03			CX 2 Stevens Extensive abnormalities in the chest. Differential diagnosis is extensive but TB and malignant neoplasms are possible etiologies. ⁴
05/23/03	CX 2 Simpson Follow-up biopsy. No pneumothorax. Nodular infiltrates and densities throughout both lungs, worse on the right. Active TB must be considered but could also be related to severe CWP and other chronic changes.		CX 1 Grimes Diffuse alveolar infiltration both upper lobes consistent with pneumonia.

⁴ The Employer introduced an attempted reading of this x-ray, and another taken on May 23, by Dr. Wheeler, but he found both to be unreadable. EX 7. Because the x-rays were taken as part of the Miner's treatment, I find that the Employer was not entitled to submit any rereadings without a showing of good cause. *See Henley v. Cowing & Company, Inc.*, BRB No. 05-0788 BLA, slip op. at 4-5 (May 30, 2006) (unpub.) (suggesting that an x-ray reading which was part of the treatment records was not subject to rebuttal, and instructing the Administrative Law Judge on remand to reconsider admissibility of a rereading offered by the Employer which was admitted at the original hearing). As the Employer failed to show good cause for rebutting x-rays taken during treatment, I have not considered either reading by Dr. Wheeler.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
07/03/03			CX 1 Grimes Increase in diffuse pulmonary disease with a mixed alveolar and interstitial pattern. Differential diagnoses include carcinoma, pneumonia, alveolitis, pneumonitis, drug or poison toxicity.
10/13/03	DX 15 Kendall BCR/B ILO Classification 3/3 Large Opacities A		DX 16 Barrett BCR/B Read for quality only Quality 1 (Good)
01/28/04			CX 1, 2 Grimes Interval increase in diffuse disease with mixed alveolar and interstitial pattern compared to 07/03/03. Differential diagnoses include carcinoma, pneumonia, alveolitis, pneumonitis, drug or poison toxicity. Recommend bronchoscopy and biopsy, CT scan.
03/19/04			CX 1, 2 Grimes Partial clearing of consolidation compared to 01/28/04. Differential diagnosis to consider is inflammatory processes. Recommend follow-up with CT scan.
03/20/04			CX 1 Name illegible No evidence of active disease. Rest of impression illegible.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
04/11/05	CX 7 Alexander BCR/B ILO Classification 3/2 Large Opacities B	EX 4 Wheeler BCR/B ILO Classification 0/1	
06/01/05		EX 1 Wheeler BCR/B	
10/24/05	CX 6 Baker B ILO Classification 3/+C		EX 6 Wheeler BCR/B Unreadable

X-ray interpretations from the prior claim appear on the following chart:

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
01/10/00	DX 1-38 Barrett BCR/B ILO Classification 1/2	DX 1-40 Forehand B	
	DX 1-39 McLoud BCR/B ILO Classification 1/2		

CT Scans

CT scans may be used to diagnose pneumoconiosis and other pulmonary diseases. The regulations provide no guidance for the evaluation of CT scans. They are not subject to the specific requirements for evaluation of x-rays, and must be weighed with other acceptable medical evidence. *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31, 1-33-1-34 (1991).

Dr. Lively at the University of Virginia reviewed a CT scan of the Claimant's chest in a report dated June 1, 1999, as part of the Claimant's examination and evaluation on referral from one of his doctors. CX 4. She noted that it revealed "lung markings consistent with pneumoconiosis ..." The original report is not in the record.

Dr. Davis performed a CT scan of the Claimant's chest on May 21, 2003. CX 1. He observed innumerable noncalcified pulmonary nodules throughout both lung fields, greatest in the lung bases. Many were less than 1 cm, with a few bilateral nodules larger than 1 cm. There was an area of soft tissue density measuring 7.3 cm x 2.1 cm in the right mid-lung field, which could represent a primary malignancy or metastasis. Active TB/fungal infection with military

spread of disease was also a differential diagnosis. Dr. Davis' impression was rule out malignancy, noting that active TB/fungal infection could also cause this appearance.

A CT guided needle aspiration biopsy of a mass in the Claimant's right lung taken on May 23, 2003, is described above. Dr. Wheeler prepared a report concerning his review of the CT scan of the Claimant's chest, taken in connection with the biopsy. EX 8.⁵ He said that the 8 x 4.6 cm mass contained tiny calcified granuloma "compatible with conglomerate histoplasmosis or TB more likely than large opacity of CWP [coal workers' pneumoconiosis]." He also said that infiltrate observed was more compatible with histoplasmosis or TB and not CWP, "which typically involves central mid and upper lungs, not periphery lungs and pleura." He said the Claimant was "quite young to have advanced CWP which would require high unprotected dust exposure, rare since WW2."

Dr. Davis performed a follow-up CT scan of the Claimant's chest on July 25, 2003. CX 1. He again observed multiple noncalcified nodular opacities throughout both lung fields. He also described the continued presence of a dense area of soft tissue consolidation in the right upper lobe, this time measuring 3.2 cm x 5.1 cm. He also observed some interval growth of nodules in the left lung base, where a nodule measuring 10.8 mm was noted. There was some improvement in aeration of both lung bases. Underlying inflammatory and/or neoplastic disease could not be differentiated from the nonspecific findings. He did not make an overall diagnosis but suggested a bronchoscopy or biopsy for definitive diagnosis.

Dr. Wheeler also reviewed a June 1, 2005, CT scan of the Claimant's chest. EX 2.⁶ He said that there was no pneumoconiosis. He said the scan demonstrated advanced granulomatous disease compatible with healed histoplasmosis, with conglomerate distorting hila and involving pleura. He also described mixed irregular linear and small nodular infiltrates compatible with histoplasmosis more likely than TB or sarcoid, and emphysema with bullous blebs. He said that neither the infiltrates nor the masses represented pneumoconiosis, because the infiltrates involved all lung zones and pleura, and the masses contained calcified granulomata and also involved the pleura. He said that pneumoconiosis typically involves only central mid and upper lungs. He said that high unprotected dust exposures were common during and before World War II, but have been rare since government mandates controlling dust levels beginning in the early 1970's.

Pulmonary Function Studies

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Pulmonary function studies are tests performed to measure obstruction or restriction in the airways of the lungs and the degree of impairment of pulmonary function. The greater the resistance to the flow of air, the more severe the lung impairment. Tests most often relied upon to establish disability in black lung claims measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV₁), and maximum voluntary ventilation (MVV).

⁵ Arguably rereadings of CT scans taken as part of the Claimant's medical treatment should not be admitted as impermissible rebuttal in accordance with *Henley*. In any event, considering Dr. Wheeler's rereadings in this case does not change the outcome as I have discounted his opinions as being contrary to the Claimant's biopsy results and based on speculative assumptions.

⁶ The source of the CT scan is not identified in Dr. Wheeler's reading. If his was not the original report, then the original report is not in the record.

The following chart summarizes the results of the pulmonary function studies available in this case. Pulmonary function studies submitted by the parties in connection with the current claim, in accordance with the limitations contained in 20 CFR § 725.414 (2006), appear in bold print. Treatment records are not subject to the limitations. Bronchodilators were not administered in any of the tests. In a "qualifying" pulmonary study, the FEV₁ must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV₁/FVC ratio must be 55% or less. 20 CFR § 718.204(b)(2)(i) (2006).

Ex. No. Date Physician	Age Height ⁷	FEV ₁ Pre-/ Post	FVC Pre-/ Post	FEV ₁ / FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
CX 4 06/01/99 Univ. of Virginia	43 Not recorded	3.57	4.77			No	Normal
DX 15 10/27/03 Mettu	48 73"	0.73	1.89	38.6%	14.6	Yes	Very severe pulmonary impairment. Test not acceptable per Dr. Burki.
CX 5 08/27/05 Sikder	49 73"	0.53	1.49	35.6%		Yes	Severe obstruction. Poor effort due to increased pain in right lung.
CX 6 10/24/05 Baker	50 71.75"	1.54	2.71	57		Yes	Severe obstruction.

The following chart summarizes the results of the pulmonary function study available in connection with the prior claim. No bronchodilators were administered.

⁷ The fact-finder must resolve conflicting heights of the Miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221, 1-223 (1983); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109, 114, 116 (4th Cir. 1995). As there is a variance in the recorded height of the Miner from 71.75" to 73" I have taken the mid-point (72.4") in determining whether the studies qualify to show disability under the regulations.

Ex. No. Date Physician	Age Height	FEV ₁	FVC	FEV ₁ / FVC	MVV	Qualify?	Physician Impression
DX 1-49 01/10/00 Forehand	44 72	3.41	4.8	71%	94	No	Normal

Arterial Blood Gas Studies

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The blood sample is analyzed for the percentage of oxygen (pO₂) and the percentage of carbon dioxide (pCO₂) in the blood. A lower level of oxygen (O₂) compared to carbon dioxide (CO₂) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled.

The following chart summarizes the arterial blood gas studies available in this case. Arterial blood gas studies submitted by the parties in connection with the current claim in accordance with the limitations contained in 20 CFR § 725.414 (2006) appear in bold print. Treatment records are not subject to the limitations. A "qualifying" arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically contraindicated. 20 CFR § 718.105(b) (2006).

Exhibit Number	Date	Physician	pCO ₂ at rest/ exercise	pO ₂ at rest/ exercise	Qualify?	Physician Impression
CX 4	06/01/00	University of Virginia	41	80	No	
DX 15	10/27/03	Mettu	41.4 40.9	73.0 81.0	No No	
CX 3	03/20/04	Highlands Regional Hospital	36	71	No	
CX 6	10/24/05	Baker	34	64	Yes	Severe resting hypoxemia

The following chart summarizes the arterial blood gas study available in connection with the prior claim.

Exhibit Number	Date	Physician	pCO ₂ at rest/ exercise	pO ₂ at rest/ exercise	Qualify?	Physician Impression
DX 1	01/10/00	Forehand	38 38	71 70	No No	No evidence of resting or exercise-induced arterial hypoxemia.

Medical Opinions

Medical opinions are relevant to the issues of whether the miner has pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis caused the miner's disability. A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 CFR §§ 718.202(a)(4) (2006). Thus, even if the xray evidence is negative, medical opinions may establish the existence of pneumoconiosis. Taylor v. Director, OWCP, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 CFR § 718.202(a)(4) (2006). Where total disability cannot be established by pulmonary function tests, arterial blood gas studies, or cor pulmonale with right-sided heart failure, or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may nevertheless be found if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. 20 CFR § 718.204(b)(2)(iv) (2006). With certain specified exceptions not applicable here, the cause or causes of total disability must be established by means of a physician's documented and reasoned report. 20 CFR § 718.204(c)(2) (2006). The record contains the following medical opinions relating to this case.

Treatment Records

Dr. Dinkar Patel referred the Claimant to the University of Virginia after he began to notice weakness and fatigue associated with intermittent dizziness, choking sensation, and a nonproductive cough and intermittent left dull chest pain. He was seen initially on June 1, 1999. He reported working in the mines for 25 years, and smoking one-half pack of cigarettes per day for 12-13 years, quitting off and on over the years. The history noted that the Claimant's PPD was negative when last tested. The chest examination was normal. Review of chest x-rays and CT scan showed some increased lung markings consistent with pneumoconiosis as well as multiple nodules, all approximately the same size and noncalcified. The nodules seen on the x-ray were unusual for pneumoconiosis, suggesting that malignancy should also be considered. Pulmonary function tests were normal. Biopsy was recommended after an evaluation for any cardiac component to the Claimant's dyspnea. The Claimant underwent right thoracoscopic biopsy on July 16, 1999. Dr. David R. Jones provided a detailed report of the biopsy surgery preformed on the Claimant's lungs. Dr. Jones noted a 25-year history of coal mining and

smoking, with lung nodules noted on chest x-ray, confirmed by CT scan, and parenchymal disease. The most peripheral nodule in the upper lobe was biopsied. Dr. Jones diagnosed "[d]iffuse lung disease with bilateral multiple pulmonary nodules." As noted above, the pathology report is not in the record. According to the discharge summary, the Claimant was discharged in good condition with instructions to follow up with Dr. Patel. CX 4.

The Claimant's family doctor is Dr. Jagan Annabathula, of the Mud Creek Clinic. According to the American Board of Medical Specialties, Dr. Annabathula is Board-certified in Internal Medicine. Clinic progress notes and other records from May 20, 2003, to August 17, 2005, are found in CX 1. Chest examinations were reported as within normal limits or clear to auscultation unless otherwise noted.

The Claimant saw a physician's assistant at Mud Creek Clinic on May 20, 2003, complaining of pleuritic pain in his lungs and shortness of breath for the previous two weeks. The notes indicate the Claimant's history of lung biopsy in 1999, and stated that no previous chest x-rays were in the chart. Chest x-ray showed diffuse interstitial infiltrate and a consolidated infiltrate in the right upper lobe. The assessment was pneumonia, with a plan to admit the Claimant to Highlands Regional Medical Center for further evaluation and treatment by Dr. Bocado.

The Claimant was transferred from Highlands Regional Medical Center and hospitalized at Central Baptist Hospital from May 22 to 24, 2003, with pneumonia. CX 2. Initially he was in isolation due to the possibility of active tuberculosis. He underwent a bronchoscopy with washings on May 22. The washings were negative for acid fast bacillus (thus, negative for TB), fungus, and malignant cells. The postoperative diagnosis was bronchitis. On May 23, the Claimant underwent a CT-guided fine needle aspiration to confirm a diagnosis, which revealed anthracosis and fibrosis compatible with coal workers' pneumoconiosis. His symptoms improved, and he was discharged home with instructions to follow-up with an infectious disease specialist, as well as his primary care physician and pulmonologist. Discharge diagnoses included pneumonia, bronchitis, pulmonary nodule right upper lobe, coal workers' pneumoconiosis, tobacco abuse, and chronic obstructive pulmonary disease (COPD).

The Mud Creek physician's assistant's progress notes reflected that the Claimant came in for evaluation on May 30, 2003, after release from Highlands hospital and the needle biopsy at Central Baptist Hospital. He reported no chest pain or shortness of breath. He was to be scheduled for a repeat chest x-ray in three months. CX 1.

Dr. Sunil Saraf saw the Claimant at the Mud Creek Clinic on July 3, 2003. The Claimant presented with complaints of chest tightness and productive cough for the past four to five days. The Claimant reported his past abnormal x-ray and evaluation at the University of Virginia which led to a diagnosis of bilateral pneumoconiosis. Chest examination revealed occasional rhonchi and no rales. Chest x-ray showed bilateral micro and macro opacities unchanged from his prior x-ray done in May 2003. Dr. Saraf assessed bronchitis and abnormal x-ray. CX 1.

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⁸ Final laboratory results were pending when the Claimant was discharged from the hospital. The final report is not in the record, nor are there any records from an infectious disease specialist in evidence. Based on the negative testing which is in the record, and the absence of any diagnosis or treatment for any infectious disease, including TB, I conclude that TB was ruled out as a diagnosis.

The Claimant returned to Dr. Annabathula on August 12, 2003. Dr. Annabathula reported that the Claimant had recently had a second CT done on his chest., which Dr. Annabathula said was abnormal, showing increased size of the nodule on the left lower lung. Dr. Annabathula planned to refer the Claimant to Dr. Sikder for further evaluation. CX 1.

The Claimant saw Dr. Annabathula in follow up on October 17, 2003. Dr. Annabathula described the Claimant as having a history of COPD and possible pneumoconiosis with nodules on the lungs. He noted that the Claimant had been seen by Dr. Mettu for evaluation of black lung, and that the pulmonary nodules were also under investigation by Dr. Sikder. CX 1.

On October 21, 2003, Dr. Annabathula performed a pre-operative medical evaluation in anticipation of an investigative procedure by Dr. Mettu due to the Claimant's diffuse lung nodules. Dr. Annabathula said the Claimant had chronic COPD with lung nodules, and said he fell under the low risk category for any peri-operative cardiac event. CX 1.

The Claimant next saw Dr. Annabathula on December 4, 2003. Dr. Annabathula described the Claimant as having a history of COPD, pneumoconiosis, and lung nodules. Dr. Annabathula noted that the Claimant had seen Dr. Sikder in August, at which time a CT scan suggested some nodules, resulting in a recommendation for biopsy. The assessment included COPD with pneumoconiosis. Dr. Annabathula planned to refer the Claimant to Dr. Sikder with a chest x-ray. CX 1.

A Mud Creek Clinic physician's assistant's progress note for January 28, 2004, reported that the Claimant had come in for medication refills and to get a chest x-ray for Dr. Sikder. According to the note, the Claimant had a history of pulmonary nodules on his x-ray. The assessment included COPD, and the plan noted that the Claimant would follow up with Dr. Sikder the following week. A chest x-ray was taken for him to take to Dr. Sikder. CX 1.

Dr. Ayesha Sikder's records from February 3, 2004, to June 10, 2005, are in the record as CX 3. His qualifications are not in the record, and he is not listed on the website of the American Board of Medical Specialties. When Dr. Sikder saw the Claimant on February 3, 2004, he complained of sore throat, cough, and congestion. Reported symptoms also included dyspnea. On examination of his chest, Dr. Sikder reported increased AP diameter, coarse breath sounds and poor air entry. His handwritten impression is difficult to decipher, but appears to include bronchitis, COPD, silicosis, and tobacco abuse. He prescribed several medications. At a follow-up visit on February 17, 2004, the Claimant was feeling better.

On February 22, 2004, Dr. Sikder dictated a combination history and physical and pulmonary consultation summary. He reported the reason for the consultation to be abnormal chest x-ray. He noted the Claimant's history of coal dust and silica dust exposure in mostly underground coal mining for 24 years ending in 1999, and that he was an active smoker, smoking one pack a day for the past 25 years. The Claimant reported that his symptoms had grown worse the past year. He was trying to quit smoking. Dr. Sikder said that chest x-ray and CT scan showed progressive massive fibrosis; he could not exclude underlying carcinoma. He also observed changes of COPD. Pulmonary function tests showed reduced FVC and FEV₁, and overall, severe obstructive airway disease. His impression was bilateral upper lobe lung masses, worse in the right upper lobe, most probably progressive massive fibrosis of coal workers' pneumoconiosis; silicosis; end stage severe advanced chronic obstructive pulmonary disease;

and, active tobacco abuse. He scheduled the Claimant for a bronchoscopy and a PET scan. CX 3.

Dr. Sikder performed the bronchoscopy on February 23, 2004. Multiple biopsies were taken from the right upper lobe in the mass area. He also took selective brushings and performed bronchial lavage. CX 3. The pathology report from the biopsies is not in the record.

A PET scan was performed at the Pikeville Methodist Hospital on March 2, 2004, at Dr. Sikder's request. CX 1. The impression of the Radiologist was nonspecific diffuse abnormal metabolic activity throughout both lung fields which may be related to an underlying inflammatory disease process or malignancy. He recommended clinical correlation with previous radiographic or CT images of the chest for further assessment.

The Claimant returned to Dr. Sikder in follow-up to the PET scan on March 1, 2004. Dr. Sikder's impression was silicosis, PMF [progressive massive fibrosis]/ CWP, COPD and tobacco abuse. CX 3.

The Claimant returned to the Mud Creek Clinic on March 19, 2004. The physician's assistant reported that the Claimant had had an acute cough and congestion for the past week. The Claimant had mild rhonchi in the lungs. Chest x-ray showed evidence of right lobe pneumonia. The assessment included pneumonia and COPD, under the care of Dr. Sikder. The Claimant was admitted to the Highlands Regional Medical Center under the care of Dr. Tan Wani for further evaluation and treatment. CX 1.

On March 21, 2004, Dr. Sikder prepared another consultation report after seeing the Claimant in the hospital. The Claimant told Dr. Sikder he had his last cigarette the week before. Dr. Sikder said that the Claimant had chronic dyspnea and severe exercise intolerance as a baseline. He had improved to the baseline symptoms after his treatment at the hospital. Dr. Sikder's impression was chronic obstructive pulmonary disease exacerbation, complicated coal workers' pneumoconiosis, bronchitis, cannot rule out pneumonia, silicosis, tobacco abuse, and cachexia. He recommended that the Claimant be discharged from the hospital and seen at the office for follow-up.

On April 2, 2004, one week after he had been released from the hospital, Dr. Annabathula saw the Claimant. Dr. Annabathula described the Claimant as a "patient with severe pneumoconiosis, multiple nodular lesions in the lungs, came for follow-up." The Claimant denied chest pain or shortness of breath. Chest examination revealed bilateral mild expiratory wheeze. Dr. Annabathula's assessment included COPD with possible pneumoconiosis. He noted that the Claimant had an appointment with Dr. Sikder on June 1, 2004. CX 1.

At the Claimant's June 1, 2004, visit to Dr. Sikder, the Claimant complained of shortness of breath, and being easily tired. He was short of breath during the visit, and chest examination revealed increased AP diameter, coarse breath sounds, and poor air entry. Dr. Sikder scheduled a CT scan for June 7, 2004. CX 3. The results of the CT scan are not in the record.

On July 7, 2004, when the Claimant returned to the Mud Creek Clinic for follow-up, he was seen by Dr. Zia Uddin, who also assessed COPD with possible pneumoconiosis. CX 1.

The Claimant returned to Dr. Sikder for follow-up on December 1, 2004. The Claimant complained of coughing, congestion, and tiredness. Chest examination revealed increased AP diameter and poor air entry. Dr. Sikder's impression was COPD, cachexia, silicosis, and CWP.

When the Claimant saw Dr. Annabathula on January 5, 2005, he complained of sore throat and chest congestion for the past two weeks. Dr. Annabathula assessed COPD, black lung, and pharyngitis. CX 1.

The Claimant visited Dr. Annabathula on April 6, 2005. No new problems were noted. The first-listed assessment was black lung with diffuse interstitial disease, with a notation that the Claimant had a regular appointment with Dr. Sikder. CX 1.

The Claimant returned to Dr. Sikder on April 11, 2005, complaining of dyspnea, cough, wheezing, and congestion. He was using accessory muscles for breathing, an addition to Dr. Sikder's usual findings on examination. Dr. Sikder's impression included an exacerbation of the Claimant's COPD. The Claimant's symptoms and findings were essentially the same when he returned on April 13, and again on May 4, 2005, at which time Dr. Sikder described the Claimant as having end stage COPD, silicosis, and cachexia, and again on June 10, 2005.

The Claimant saw Dr. Annabathula in follow-up visits on July 6, and August 17, 2005. Diagnoses on the earlier occasion included COPD with pneumoconiosis and, later, black lung. The notes indicate that the Claimant continued treatment with Dr. Sikder for his lung problem, and that Dr. Sikder prescribed him inhalers and nebulizer medications. CX 1.

Opinions Given in Connection with the Current Claim

Dr. Mettu examined the Claimant on behalf of the Department of Labor on October 13, 2003. DX 15. He took occupational, social, family, and medical histories, and conducted a physical examination, chest x-ray, and an EKG. He reported that the Claimant worked in the mines for 24 years. He reported a smoking history of one-half of a pack per day for 23 years. The chest examination was normal. Dr. Mettu said the x-ray findings were consistent with complicated pneumoconiosis. There were no pulmonary function or arterial blood gas tests administered at the time of the examination due to the Claimant's abnormal EKG results. He was referred for cardiac evaluation, and was to return thereafter. Pulmonary function and arterial blood gas tests were conducted on October 27, 2003. Dr. Mettu reviewed the results of the pulmonary function test and noted that the Claimant had a very severe pulmonary impairment with reduced MVV. Dr. Burki reviewed the test and invalidated it due to less than optimal effort, cooperation, and comprehension. The Claimant was offered an opportunity to take another pulmonary function test, but he declined. DX 37, 40. Dr. Mettu diagnosed chronic bronchitis due to coal mine employment and smoking. Additionally, he found the Claimant to suffer from a "very severe" impairment, which he related to coal mine employment and smoking.

Dr. Sikder responded to a questionnaire from the Claimant's counsel on October 10, 2005. CX 5. He said that the Claimant worked for 24½ years in the coal mining industry. He checked the space indicating that he had treated the Claimant for a breathing condition caused by his coal mine employment. He indicated that the Claimant had been diagnosed with COPD and CWP with Progressive Massive Fibrosis based on x-rays and clinical findings. Asked to list any

other breathing problems caused by coal mine employment, Dr. Sikder listed silicosis and indicia of advanced lung disease. He indicated that the Claimant had a total disability caused by coal mine employment. Asked to explain, he said that the Claimant's FEV was 12% prior to bronchodilator treatment. He attached the results of a pulmonary function test interpreted as showing severe obstruction. However, he noted poor effort due to increased pain in the Claimant's right lung.

Dr. Glen Baker examined the Claimant at the request of his counsel on October 24, 2005. CX 6. Dr. Baker is Board certified in Internal Medicine and Pulmonary Disease and a B reader. He took occupational, social, family, and medical histories and conducted a physical examination, chest x-ray, blood gas studies, and pulmonary function testing. His initial report was prepared on the Department of Labor form; he also attached a narrative Addendum. He reported that the Claimant worked in the mines for 24½ years. He reported a smoking history of one-half of a pack per day for approximately 28 years, ending two years before the examination. The chest examination was normal. Dr. Baker read the x-ray as showing complicated pneumoconiosis, (ILO Classification of 3/+ with C opacity). The pulmonary function test showed severe obstructive impairment. The arterial blood gas study revealed severe hypoxemia at rest. Dr. Baker diagnosed complicated pneumoconiosis (based upon x-ray and coal dust exposure), COPD with severe obstructive defect (based upon the pulmonary function studies), severe hypoxemia (based upon the arterial blood gas studies), and bronchitis (based upon the medical history). He attributed the CWP to coal dust exposure, and each of the other listed conditions to coal dust exposure and cigarette smoking. Dr. Baker found that the Claimant had a severe pulmonary impairment with a decreased FEV₁, decreased pO₂, increased pCO₂, bronchitis, and coal workers' pneumoconiosis 3/+. He said each of the diagnoses contributes to the Claimant's impairment. He recommended that the Claimant follow up with another physician due to the abnormal chest x-ray.

In the Addendum to the report, Dr. Baker stated that the Claimant has both clinical and legal pneumoconiosis. He said that the biopsy and x-ray changes provide good evidence of pneumoconiosis and that the Claimant has no other condition to account for the x-ray changes. He said that the severe obstructive defect on pulmonary function testing, severe resting hypoxemia, increased pO₂, and mild bronchitis, could all be caused by coal dust exposure, and that the x-ray changes suggest that coal dust is the predominant cause. In addition, he found at most a 15-pack year smoking history, which also supported the conclusion that the Claimant's impairment is significantly related to and substantially aggravated by dust exposure, with minimal contribution by smoking. The values on pulmonary function and arterial blood gas testing were disabling. Dr. Baker said that the Claimant does not have the respiratory capacity to do to the work of a coal miner or comparable work in a dust-free environment. He further opined that pneumoconiosis, COPD, and bronchitis have all contributed to the Claimant's pulmonary impairment. More specifically, he opined that the Claimant's smoking history had little to do with the pulmonary impairment.

Opinion Given in Connection with the Prior Claim

Dr. J. Randolph Forehand examined the Claimant on behalf of the Department of Labor on January 10, 2000, in connection with the first claim. DX 1-45. Dr. Forehand is Board certified in Allergy and Immunology and Pediatrics, and is a B reader. He took occupational, social, family, and medical histories and conducted a physical examination, EKG, chest x-ray,

blood gas studies and pulmonary function testing. He reported that the Claimant worked in the mines for 24½ years. He reported a smoking history of one-half pack per day since 1988. The chest examination was normal. Dr. Baker said the x-ray results showed coal workers' pneumoconiosis with evidence of pulmonary nodules. The pulmonary function test was normal. The arterial blood gas study showed no hypoxemia at rest or with exercise, and no metabolic disturbance. Dr. Baker diagnosed atypical coal workers' pneumoconiosis with evidence of pulmonary nodules, status post right lung biopsy. As to the etiology, he said that the results of the lung biopsy are available and the etiology was certain, repeating that the Claimant had atypical coal workers' pneumoconiosis. He said that there was no significant respiratory impairment present.

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

- (a) For the purpose of the Act, 'pneumoconiosis' means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or 'clinical,' pneumoconiosis and statutory, or 'legal,' pneumoconiosis.
- (1) Clinical Pneumoconiosis. 'Clinical pneumoconiosis' consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthracosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.
- (2) Legal Pneumoconiosis. 'Legal pneumoconiosis' includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
- (b) For purposes of this section, a disease 'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
- (c) For purposes of this definition, 'pneumoconiosis' is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 CFR § 718.201 (2006).

In this case, the Claimant's medical records indicate that he has been diagnosed with pneumoconiosis and chronic obstructive pulmonary disease, which can be encompassed within the definition of legal pneumoconiosis. *Ibid.*; *Richardson v. Director, OWCP*, 94 F.3d 164 (4th Cir. 1996); *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995). However, only chronic obstructive pulmonary disease caused by coal mine dust constitutes legal pneumoconiosis. *Eastover Mining Co. v. Williams*, 338 F.3d 501, 515 (6th Cir. 2003); 65 Fed. Reg. 79938 (2000) ("[t]he Department reiterates ... that the revised definition does not alter the former regulations' ... requirement that each miner bear the burden of proving that his obstructive lung disease did in fact arise out of his coal mine employment, and not from another source.").

Twenty CFR § 718.202(a) (2006) provides that a finding of the existence of pneumoconiosis may be based on (1) chest x-ray; (2) biopsy or autopsy; (3) application of the presumptions described in §§ 718.304 (irrebuttable presumption of total disability due to pneumoconiosis if there is a showing of complicated pneumoconiosis), 718.305 (not applicable to claims filed after January 1, 1982), or 718.306 (applicable only to deceased miners): or, (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. In this case, the biopsy evidence conclusively establishes that the Claimant has at least simple pneumoconiosis. In order to determine whether the evidence establishes the existence of complicated pneumoconiosis in this case, therefore, I must consider the chest x-rays, CT scans, and medical opinions.

Pursuant to 20 CFR § 718.304(a), the existence of complicated pneumoconiosis may be established when diagnosed by a chest x-ray which yields one or more large opacities (greater than 1 centimeter) and would be classified in Category A, B, or C. X-ray evidence is not the exclusive means of establishing complicated pneumoconiosis under § 718.304. Its existence may also be established under § 718.304(b) by biopsy or autopsy or under § 718.304(c), by an equivalent diagnostic result reached by other means. The Benefits Review Board has held that the Administrative Law Judge must first determine whether the relevant evidence in each category tends to establish the existence of complicated pneumoconiosis and then must weigh together the evidence at each subsection before determining whether invocation of the irrebuttable presumption under § 718.304 has been established. *Melnick v. Consolidated Coal Co.*, 16 B.L.R. 1-31, 1-33 (1991) (*en banc*). The United States Court of Appeals for the Sixth Circuit has held that "[x]-ray evidence of opacities larger than one centimeter does not automatically trigger the irrebuttable presumption when conflicting evidence exists." *Gray v. SLC Coal Co.*, 176 F.3d 382, 388 (6th Cir. 1999)

Pneumoconiosis is a progressive and irreversible disease. Labelle Processing Co. v. Swarrow, 72 F.3d 308, 314-315 (3rd Cir. 1995); Lane Hollow Coal Co. v. Director, OWCP, 137 F.3d 799, 803 (4th Cir. 1998); Woodward v. Director, OWCP, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. See Mullins Coal Co. of Virginia v. Director, OWCP, 484 U.S. 135, 151-152 (1987); Eastern Associated Coal Corp. v. Director, OWCP, 220 F.3d 250, 258-259 (4th Cir. 2000); Crace v. Kentland-Elkhorn Coal Corp., 109 F.3d 1163, 1167 (6th Cir. 1997); Rochester & Pittsburgh Coal Co. v. Krecota, 868 F.2d 600, 602 (3rd Cir. 1989); Stanford v. Director, OWCP, 7 B.L.R. 1-541, 1-543 (1984); Tokarcik v. Consolidated Coal Co., 6 B.L.R. 1-666, 1-668 (1983); Call v. Director, OWCP, 2 B.L.R. 1-146, 1-148-1-149 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. Woodward, 991 F.2d at 319-320; Adkins v. Director, OWCP, 958 F.2d 49 (4th Cir. 1992); Burns v. Director, OWCP, 7 B.L.R. 1-597, 1-600 (1984).

In this case, there are readings of 14 x-rays taken during treatment between 1999 and 2005, only one of which mentions the possible presence of coal workers' pneumoconiosis (Dr. Simpson's reading of an x-ray taken May 23, 2003), and it is not classified as required by the regulations. Whether an x-ray interpretation which is **silent** as to pneumoconiosis should be interpreted as **negative** for pneumoconiosis, is an issue of fact for the ALJ to resolve. *Marra v. Consolidation Coal Co.*, 7 B.L.R. 1-216 (1984); *Sacolick v. Rushton Mining Co.*, 6 B.L.R. 1-930 (1984). Most readings of treatment x-rays described abnormalities in both lungs, and several mentioned multiple pulmonary nodules, although the readers varied in their opinions as to the etiology. I find that the treatment x-rays should not be interpreted to be negative for pneumoconiosis. As noted above, I have not considered Dr. Wheeler's rereadings of two x-rays taken during treatment in May 2003. As Dr. Wheeler found both to be unreadable, considering his readings would not change my view that the treatment x-rays should not be construed to be negative for pneumoconiosis.

Of the x-rays read in connection with the claims, there were both positive and negative readings for simple and complicated pneumoconiosis. For cases with conflicting x-ray evidence, the regulations specifically provide,

... where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays.

20 CFR § 718.202(a)(1) (2006); *Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344 (1985); *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31, 1-37 (1991). Readers who are Board-certified Radiologists and/or B readers are classified as the most qualified. The qualifications of a certified Radiologist are at least comparable to if not superior to a physician certified as a B reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985). Greater weight may be accorded to x-ray interpretations of dually qualified physicians. *Sheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128, 1-131 (1984). A Judge may consider the number of interpretations on each side of the issue, but not to the exclusion of a qualitative evaluation of the x-rays and their readers. *Woodward*, 991 F.2d at 321; *see Adkins*, 958 F.2d at 52.

The January 10, 2000, x-ray, taken in connection with the Claimant's prior claim, was read as positive for simple pneumoconiosis by a dually qualified physician, and negative by a B reader. I find this x-ray to be positive for simple pneumoconiosis, based on the superior qualifications of the dually qualified reader.

The October 13, 2003, x-ray, submitted in connection with the current claim, was read as positive for simple and complicated pneumoconiosis by Dr. Kendall, who is dually qualified. There are no negative readings. I find this x-ray to be positive.

The April 11, 2005, x-ray was read as positive for simple and complicated pneumoconiosis by Dr. Alexander, a Board-certified Radiologist and B reader. Dr. Wheeler, also a Board-certified Radiologist and a B reader, read the x-ray as negative for pneumoconiosis. Although Dr. Wheeler classified the film as negative (0/1), he also observed an 8 x 5.5 cm mass in the right lung, and an 8 x 5 cm mass in the left lung, along with moderate nodular infiltrates in both lungs, "compatible with histoplasmosis more likely than TB or cancer," and moderate

emphysema with scattered bullous blebs. He said that it was unlikely that the Claimant had complicated pneumoconiosis because he was young, and NIOSH began controlling dust levels in the mines in the early 1970's. For the Claimant to have complicated pneumoconiosis, Dr. Wheeler said, it "would require very high dust exposures without respiratory protection of the type seen in drillers during and before WW2 [World War II]." Thus, it appears that he declined to classify the x-ray as positive for complicated pneumoconiosis because of assumptions he made about the amount of dust the Claimant was exposed to. This suggests that his reading was subjective rather than objective. For this reason, I give greater weight to Dr. Alexander's positive reading and find that this x-ray was positive for complicated pneumoconiosis.

The June 1, 2005, x-ray was read as negative by Dr. Wheeler, a Board-certified Radiologist and B reader. There are no positive readings. Thus, I find this x-ray to be negative for pneumoconiosis. In his report, however, Dr. Wheeler this time observed an 11 x 6 cm mass in the left mid and lower lung, a 9 x 6 cm mass in the right mid and upper lung, and a 3.5 cm mass in the left lower lung, "all compatible with conglomerate granulomatous disease, histoplasmosis more likely than sarcoid or TB." He also observed mixed linear, irregular, and small nodular infiltrates in the lower lungs, and the periphery of the mid and upper lungs, compatible with histoplasmosis. He also observed moderate emphysema with bullous blebs. He again commented that large opacities of coal workers' pneumoconiosis were unlikely because there was pleural involvement, and the Claimant was quite young, beginning work after government control of dust levels in mines; he said most large opacities are seen in drillers working without respiratory protection during and before World War II. He said an exact diagnosis is needed for any advanced lung disease and should have been made with biopsy or microbiology. In fact, of course, the Claimant's biopsy results did confirm that he has pneumoconiosis.

The October 24, 2005, x-ray was read as positive for complicated pneumoconiosis by Dr. Baker, a B reader. Dr. Wheeler, a Board-certified Radiologist and B reader, determined the x-ray to be unreadable. As the dually qualified reader found the x-ray to be unreadable, I find that this x-ray is inconclusive on the presence of pneumoconiosis.

Of the x-rays classified in accordance with the regulations, three were positive, one was negative, and one was inconclusive. Thus, the preponderance of the x-ray evidence is positive for pneumoconiosis. Moreover, the positive readings of the x-rays show a progression from simple to complicated pneumoconiosis, with ever increasing profusion and size of opacities. I, therefore, find that the x-rays establish the presence of simple and complicated pneumoconiosis.

In addition to the x-rays, the records refer to four CT scans of the Claimant's lungs. Dr. Lively said that the June 1999 scan was consistent with pneumoconiosis. Dr. Davis performed a CT scan on the Claimant on May 21, 2003, but made no diagnosis. He suspected malignancy or TB, but did not suggest pneumoconiosis as a possible cause. Thus, this report is not probative on the issue of pneumoconiosis. Dr. Wheeler read the CT scan of May 23, 2003, taken in connection with a biopsy of a mass in the Claimant's right lung, as negative for pneumoconiosis. However, the biopsy results contradict Dr. Wheeler's reading of the CT scan, as the biopsy was positive for pneumoconiosis. Dr. Wheeler also read a June 1, 2005, CT scan as negative. His reading of this CT scan was also influenced by his assumptions about the

Claimant's exposure to coal dust. Thus, I accord his negative CT readings little weight. Taken together, the CT scans are inconclusive.

I must next consider the medical opinions. The Claimant can establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co.*, 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the Judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields*, above. Whether a medical report is sufficiently documented and reasoned is for the Judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149, 1-155 (1989) (*en banc*).

In this case, all four of the doctors who gave an opinion in both claims (Drs. Forehand, Mettu, Sikder, and Baker) agreed that the Claimant has pneumoconiosis. In the current claim, all three (Drs. Sikder, Mettu, and Baker) agreed that he has complicated pneumoconiosis. Dr. Sikder is the doctor primarily responsible for treating the Claimant for his lung problems. He diagnosed both complicated pneumoconiosis and end stage COPD. His diagnosis is supported by biopsy, x-ray and other objective testing, and his ongoing treatment of the Claimant, reflected in office visit and hospital records. Drs. Forehand, Mettu, and Baker each had the opportunity to examine the Claimant and administer objective testing. I find that all of their opinions are well documented and well reasoned. Dr. Baker explicitly found that the Claimant has both clinical and legal pneumoconiosis. I conclude that the medical opinion evidence supports the conclusion that the Claimant has complicated clinical pneumoconiosis and legal pneumoconiosis.

The biopsy, x-ray, and medical opinion evidence, considered separately or together, all support a finding that the Claimant has complicated pneumoconiosis. The CT scan evidence, although inconclusive, does not significantly diminish the overwhelming weight of the evidence in favor of a finding of pneumoconiosis. Thus, I find that the Claimant has established that he has pneumoconiosis within the meaning of the Act and the regulations.

Causal Relationship Between Pneumoconiosis and Coal Mine Employment

The Act and the regulations provide for a rebuttable presumption that pneumoconiosis arose out of coal mine employment if a miner with pneumoconiosis was employed in the mines for 10 or more years. 30 U.S.C. § 921(c)(1); 20 CFR § 718.203(b) (2006). The Claimant was employed as a miner for at least 24 years and, therefore, is entitled to the presumption. The Employer has not offered evidence sufficient to rebut the presumption. Moreover, to the extent that the Claimant has legal, as opposed to clinical pneumoconiosis, the causal relationship is established by the opinion of Dr. Baker, who attributed the Claimant's COPD to the combined effects of exposure to coal dust and cigarette smoking. I conclude that the Claimant's pneumoconiosis was caused by his coal mine employment.

Total Pulmonary or Respiratory Disability

As noted above, the Sixth Circuit standard for review of a subsequent claim requires that the entire record be considered if a claimant establishes one of the elements of entitlement previously decided against him. In reaching my decision, I first considered only the evidence in the current claim to determine whether the Claimant has established total pulmonary or respiratory disability. Based on the evidence in the current claim, I then concluded that the Claimant has complicated pneumoconiosis and is, therefore, entitled to the irrebuttable presumption of total disability due to complicated pneumoconiosis. I also determined that pulmonary function and blood gas studies, and medical opinion evidence also establish total disability in the current claim. I then reviewed the entire record from both claims to reach my ultimate decision that the Claimant is entitled to benefits.

A miner is considered totally disabled if he has complicated pneumoconiosis, 30 U.S.C. § 921(c)(3), 20 CFR § 718.304 (2006), or if he has a pulmonary or respiratory impairment to which pneumoconiosis is a substantially contributing cause, and which prevents him from doing his usual coal mine employment and comparable gainful employment, 30 U.S.C. § 902(f), 20 CFR § 718.204(b) and (c) (2006). The regulations provide five methods to show total disability other than by the presence of complicated pneumoconiosis: (1) pulmonary function studies; (2) blood gas studies; (3) evidence of cor pulmonale; (4) reasoned medical opinion; and, (5) lay testimony. 20 CFR § 718.204(b) and (d) (2006). Lay testimony may only be used in establishing total disability in cases involving deceased miners, and in a living miner's claim, a finding of total disability due to pneumoconiosis cannot be made solely on the miner's statements or testimony. 20 CFR § 718.204(d) (2006); *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-106 (1994).

The pulmonary function studies show a striking decline in the Claimant's pulmonary function between 1999 and 2005. Tests in 1999 and 2000 produced normal results. Tests in 2003 and 2005 produced results showing severe obstruction. Although two of the three tests have been invalidated, the most recent, by Dr. Baker, has not. Moreover, Dr. Sikder suggests that the Claimant was unable to give full effort in his 2005 test due to pain. I find that the pulmonary function tests support a finding of disability.

The arterial blood gas studies show a similar decline in the Claimant's gas exchange. Five tests administered between January 2000 and October 2005 showed a steady decline in oxygenation. The final test, by Dr. Baker in October 2005, resulted in a qualifying value at rest, characterized by Dr. Baker as severe resting hypoxemia.

The medical opinion evidence also shows a change over time, paralleling the objective testing. Dr. Forehand, who examined the Claimant in January 2000, found no significant respiratory impairment. By the time of Dr. Mettu's examination in October 2003, the Claimant had what Dr. Mettu characterized as a very severe impairment. In 2005, both Dr. Sikder and Dr. Baker said that the Claimant no longer had the capacity to do the work of a coal miner or comparable work in a dust-free environment.

The presence of complicated pneumoconiosis, invoking the irrebuttable presumption, the pulmonary function tests, the arterial blood gas studies, and the medical opinion evidence, all

support the conclusion that the Claimant is totally disabled by a pulmonary and respiratory impairment, and I so find.

Causation of Total Disability

In order to be entitled to benefits, the Claimant must establish that pneumoconiosis is a "substantially contributing cause" to his disability. A "substantially contributing cause" is one which has a material adverse effect on the miner's respiratory or pulmonary condition, or one which materially worsens another respiratory or pulmonary impairment unrelated to coal mine employment. 20 CFR § 718.204(c) (2006); *Tennessee Consol. Coal Co. v. Kirk*, 264 F.3d 602, 610 (6th Cir. 2001). Drs. Mettu, Sikder, and Baker are all of the opinion that coal dust exposure caused or contributed to the Claimant's impairment and disability. There are no contrary opinions. I find that the Claimant has established that his disability was caused by exposure to coal dust.

Date of Entitlement

In the case of a miner who is totally disabled due to pneumoconiosis, benefits commence with the month of onset of total disability. Medical evidence of total disability does not establish the date of entitlement; rather, it shows that a claimant became disabled at some earlier date. *Owens v. Jewell Smokeless Coal Corp.*, 14 BLR 1-47, 1-50 (1990). Where the evidence does not establish the month of onset, benefits begin with the month that the claim was filed, unless the evidence establishes that the miner was not totally disabled due to pneumoconiosis at any subsequent time. 20 CFR § 725.503(b) (2006); *Harris v. Old Ben Coal Co.*, 23 B.L.R. 1-____, BRB No. 04-0812 BLA (Jan. 27, 2006), slip op. at 17.

The Claimant filed his claim for benefits on August 25, 2003. When he was examined by Dr. Mettu in October 2003, he was already totally disabled, as demonstrated by an x-ray showing complicated pneumoconiosis. The regulation regarding subsequent claims also provides, however, "[i]n any case in which a subsequent claim is awarded, no benefits may be paid for any period prior to the date upon which the order denying the prior claim became final." 20 CFR § 725.309(d)(5). The District Director issued his proposed decision and order on the Claimant's prior claim on March 22, 2000. As he took no further action on that claim, it became final one year later, on March 22, 2001. The record does not establish when the Claimant first became disabled after March 22, 2001, however, as there was a gap in test results between January or June 2000 and October 2003, and there were no x-ray or equivalent findings of complicated pneumoconiosis until October 2003.

As I cannot determine when the Claimant first became disabled, I find that the Claimant is entitled to benefits commencing in August 2003, the month in which he filed his claim.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

Having considered all of the relevant evidence, I find that the Claimant has established that he has pneumoconiosis arising out of his coal mine employment, and a totally disabling pulmonary or respiratory impairment caused by pneumoconiosis. Thus, the Claimant has met his burden of showing a change in an applicable condition of entitlement pursuant to § 725.309(d). Accordingly, the Claimant is entitled to benefits under the Act.

ATTORNEY FEES

The regulations address attorney's fees at 20 CFR §§ 725.362, .365, and .366 (2006). The Claimant's attorney has not yet filed an application for attorney's fees. The Claimant's attorney is hereby allowed thirty days (30) days to file an application for fees. A service sheet showing that service has been made upon all parties, including the Claimant, must accompany the application. The other parties shall have ten (10) days following service of the application within which to file any objections, plus five (5) days for service by mail, for a total of fifteen (15) days. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

The claim for benefits filed by the Claimant on August 25, 2003, is hereby GRANTED.

Α

ALICE M. CRAFT Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the Administrative Law Judge's Decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the Administrative Law Judge's Decision is filed with the District Director's Office. *See* 20 C.F.R. §§ 725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, D.C., 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, D.C., 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the Administrative Law Judge's Decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).